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Inter-professional perspectives of dementia services and care in England: Outcomes of a focus group study

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Abstract

Many people living with dementia are supported at home using a variety of health and social care services. This paper reports the findings from a focus group study undertaken with staff in community mental health teams to explore areas for improvement in relation to national policies and recommendations for dementia care. Two focus groups were held with staff ($n = 23$) in 2011 to discuss topics including service delivery, information and communication, and provision of health and community care for people with dementia. Respondents identified problems with information sharing and incompatible electronic systems; inflexibility in home care services; and poor recognition of dementia in hospital settings. General practitioners had developed a greater awareness of the disease and some community services worked well. They felt that budgetary constraints and a focus on quality indicators impeded good

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dementia care. Key areas suggested by staff for improvements in dementia care included the implementation of more flexible services, dementia training for health and social care staff, and better quality care in acute hospital settings.

Keywords
care services, community mental health team, dementia care, professional staff

Introduction

As a consequence of an ageing population, dementia has become a major challenge for the health and social care services of many countries across the developed and developing world (Ferri et al., 2005; Prince, 2004; Prince, Livingston, & Katona, 2007). Worldwide, total costs for dementia care were estimated to be around $604 billion in 2010, creating a substantial financial pressure on governments (Wimo et al., 2013). In line with a projected growth in the older population, the economic cost of dementia care in the United Kingdom (UK) has been forecast to increase (Knapp et al., 2007). An increasing number of countries across the world are introducing national strategies to enhance cost-effective care and treatment for people with dementia. In some countries, such strategies are well-established (Australian Health Ministers' Conference, 2006; Norwegian Ministry of Health and Care Services, 2007). France has recently introduced a third Alzheimer's Plan since 2001 and progress has been observed in a number of its key measures (Guisset-Martinez, 2012).

The national dementia strategy in England was introduced in 2009 and reinforced in 2012 (Department of Health, 2009, 2012a). Both this and other policy guidelines have emphasized a preference for dementia care to be delivered by localised and integrated health and social care agencies (Department of Health, 2001; National Institute for Health and Clinical Excellence (NICE) – Social Care Institute for Excellence (SCIE), 2006; NICE, 2010). Research studies which have investigated the provision of community services across the health and social care divide for older people with mental health problems reported largely positive outcomes (Challis et al., 2009; Kodner, 2006). However internationally, the integration of mental health and social care services remains a challenge due to differences in professional culture, organisational arrangements and funding structures (Callaly & Fletcher, 2005; Tucker et al., 2009).

The majority of people with dementia remain in the community with just over one-third living in some form of long-stay care home (Knapp et al., 2007). Home care, which can provide practical assistance with personal care, medication management or domestic activities, is the main type of community care service supporting people at home including those with dementia (National Statistics, 2013). Over recent years despite a steady increase in the number of hours of home care provision to older people, there has been a marked reduction in the number of households being supported (Knapp et al., 2007; National Statistics, 2009), indicating a shift to a more intensive form of home support. Many people with dementia also have co-morbidities and are at greater risk of admission to acute hospital care (National Audit Office (NAO), 2007; Toot, Devine, Akporobaro, & Orrell, 2013). However in some cases, their care is compromised due to insufficient staff training and long hospital stays (Alzheimer's Society, 2009; Royal College of Psychiatrists, 2011). Consequently, improvements to care pathways for the management

of people with dementia in general hospitals and better availability of specialist liaison teams have been suggested (NICE, 2010; Royal College of Psychiatrists, 2006, 2013).

In England, key objectives of government policy have been to ensure wider availability of mental health services for older people with dementia and to provide better access to specialist care based in the community (Department of Health, 2000, 2001; Department of Health & Care Services Improvement Partnership (CSIP), 2005). Other countries have similarly implemented models of integrated and comprehensive mental health care for older adults (Mental Health Commission of Canada, 2011). However, there is large variation between European countries in the availability of and access to mental health services particularly in relation to community care provision (WHO Europe, 2008). In England, specialist care within mental health services is generally provided by a multidisciplinary community mental health team. This can comprise a variety of professionals ideally including old age psychiatry, community psychiatric nursing, social work, clinical psychology and occupational therapy (OT) (Department of Health, 2001). Nevertheless, social work input remains variable within such teams (Huxley et al., 2011; Wilberforce et al., 2011). The functions of a Community Mental Health Team for Older People (CMHTOP) are to provide multidisciplinary assessment, care planning, treatment, care co-ordination and follow up care to people with mental health problems including dementia and their carers and also offer appropriate advice and support to other health care professionals (Department of Health & CSIP, 2005; Royal College of Psychiatrists, 2006).

In this paper, we report the national findings from a European focus group study conducted with professional staff working within community-based mental health services. England was one of eight countries geographically spread across Europe (Estonia, Finland, France, Germany, Netherlands, Sweden, Spain, England) that took part in a larger European Union funded prospective cohort study – RightTimePlaceCare (2010–2013). The design and protocol for the study have been previously reported (Verbeek et al., 2012). As part of this programme of research, a qualitative approach was adopted and a series of focus group interviews were carried out using a semi-structured guide for discussion. These were undertaken with people with dementia and carers, and also separately with professional staff who were members of CMHTsOP. This approach permitted the discussion of salient aspects of dementia care and the provision of dementia support services from several different perspectives. Previously reported findings from the focus groups held with people with dementia and carers highlighted their experience of diagnosis and the importance to them of access to appropriate care and flexible and timely services (Sutcliffe, Roe, Jasper, Jolley, & Challis, 2013). This paper, on the other hand, reports the outcomes from interviews held with the CMHTsOP who, although discussing broadly similar topics, observed dementia care and its delivery from different viewpoints. These interviews also explored key areas for improvement from the position of professionals working in dementia care in relation to national policies and recommendations.

Method

Samples

Two focus groups were held with convenience samples of 23 staff participants from two localities within a large National Health Service (NHS) Mental Health Trust in the north

west of England. Participants were recruited via the Trust, by invitation on behalf of the project team. Team managers in each locality were asked to invite a range of professional staff to take part from each of their multidisciplinary teams responsible for the care of people with dementia. Ethical approval was granted by the National Research Ethics Service, North West 5 Research Ethics Committee (11/NW/0003) for the project as a whole, which included the focus group component.

Data collection

The focus groups took place during December 2011 and were carried out at lunchtime on the working premises to ensure that as many invited members of staff as possible could attend. They were held in rooms that were quiet to help facilitate the focus group discussions. Both focus groups ran for a period of 1 h and lunchtime refreshments were provided. One to two weeks prior to the focus group meetings, team managers were sent information about the study and before the sessions, participants were given information sheets and had the opportunity to ask questions of the project team. It was explained that all information provided was confidential and would remain anonymous, along with any direct quotes, and that the discussion would be audio recorded. All staff participants agreed to this and gave their signed consent. In addition, brief details were collected regarding their workplace setting, profession, and experience of dementia care. Both focus groups were audio recorded and facilitated by a member of the project team and an observer recorded details of seating plans and took notes. The facilitator outlined the expected duration of the meeting and gave a brief introduction to the project as a whole and described the main aims of the discussion to the participants. At each focus group the same format was adhered to, using a semi-structured guide for discussion (Figure 1), which covered a number of topics. These included: care services provision and support; communication and information sharing; perceptions of services working well and that are valued; barriers to good service delivery; and suggestions for the improvement or development of future services.

- Discussion of local care service availability and delivery
- What are the issues relating to information sharing, communication and interaction between different care sectors?
- Which services are working well, and why?
- Which services are working less well, and why?
- How would you change or improve the dementia care system?

Figure 1. Semi-structured guide for discussion.

Analysis

Audio recordings of the focus groups were professionally transcribed. Both transcripts were checked by a member of the project team who had attended the focus groups against the recordings for accuracy and any omissions. Each member of the project team read the completed and validated transcripts. Discussions between two project members ensured systematic coding of data and led to the subsequent identification of preliminary relevant themes and sub-themes using content analysis (Stevens, 1996). Rigour was assured by discussion and consensus until saturation was reached. The data on workplace setting, profession and experience of dementia care were summarised and are presented below.

Findings

Characteristics of the sample

In total, 23 people attended the focus groups. Group A was attended by 13 members of staff comprising nine females and four males; a consultant old age psychiatrist and a psychologist were invited but were unable to attend on the day itself. All participants from group A were based in the community, and had an average of over 18 years' experience of dementia care. In group B, 10 members of staff attended, comprising eight females and two males with some participants based in the community and some hospital-based. This group had just under 19 years' experience of dementia care on average. Table 1 illustrates the staff participants' workplace settings, occupation and experience. The experience level of participants ranged from student nurses on their first placement in dementia care through to managers, community practitioners and an old age psychiatrist with over 36 years' experience. The topics which were covered in the focus groups and subsequently coded into relevant themes and sub-themes are discussed below.

Service delivery

People with dementia and their carers were supported by CMHTsOP using a mix of services both from within the teams and external statutory and voluntary services

Table 1. Professional staff participant details.

Participants	Workplace	Profession	Experience in dementia care
Group A	Community	2 team managers	Over 25 years
	Community	4 social workers	Between 8 years and 25 years
	Community	1 support worker	25 years
	Community	2 student nurses	First placements in dementia care
	Community	2 carer services officers	Between 20 years and 32 years
	Community	2 community psychiatric nurses	Between 20 years and 25 years
Group B	Both	1 service manager	25 years
	Hospital	1 old age psychiatrist	36 years
	Both	4 nurses	Between 15 years and 17 years
	Community	3 community psychiatric nurses	Between 12 years and 20 years
	Community	1 assistant practitioner (carer support worker)	6 years

accessible to the teams, often via the general practitioner (GP). A residential home team provided support to care home staff and residents with dementia, and home intervention teams (HIT) and telecare services assisted people with dementia in their own homes. Services such as re-ablement and discharge liaison teams, designed to prevent admission or re-admission to hospitals, offered support to people with dementia. Each focus group contained support workers who engaged with service users with mental health difficulties and their carers. These roles ranged from support, time and recovery (STAR) support workers for people with any mental health problems working alongside members of the CMHTOP, to more specific dementia support workers based within the teams. All of these services were viewed positively by group participants as illustrated by the quotes below:

> "...I think more people are getting a better service than they used to have ... more people are being accommodated ... by re-ablement services" (Group A)
> "I started in post in July to support carers in older people's services so I work with dementia and the functional teams and we are getting there ..." [support worker] (Group B)

In contrast, participants in both groups found it difficult to access some community services for people with dementia, for example, OT and physiotherapy, however conversely a community dental service was praised. In addition, focus group participants felt that their work with the carers of people with dementia was an important aspect of service delivery, as shown below:

> "... a lot of the interventions that you deliver are to the carer, not necessarily to the person and that is about providing education, helping people to look at a different way of managing things, for themselves and for the person..." (Group B)

Information sharing and communication

In both focus groups, participants were asked about how information was shared between different services and the majority reported that incompatible electronic systems hindered information sharing across health and social care services. Many participants reported that difficulties with systems and databases that did not share patient information caused problems in continuity of care for people with dementia, as shown below:

> "When a person is admitted onto a general ward, [CMHT staff] can't find out whether they are open to this team, or another team, because the systems don't work together, so sometimes they may have been on the ward for two or three days ... and decisions have been made because you have not been contacted ..." (Group A)
> "...where we have serious incidents it is sometimes around that interface [between the Trusts] because we don't all have the same systems in terms of electronic systems for reporting, we have completely different sets of notes and none of that information is shared ..." (Group B)

Despite this lack of electronic compatibility between services, participants reported ways to work around this when attempting to share information, for example staff in the CMHTOP visited the wards in person to access information and discharge plans were copied and forwarded to relevant parties. Conversely, information sharing between GPs and

CMHTsOP was reported by some participants as having improved resulting in receipt of more detailed information when receiving referrals, as illustrated below:

> "...We now get all the blood results, they'll send us an ECG, if they have got a CT scan on file, that will come with them, a list of medication comes, medical histories come, we work really hard with GPs, and that has obviously filtered through..." (Group B)

The majority of participants in both groups agreed that communication was a key component to successful working and achieving positive outcomes for people with dementia. However, participants described barriers to communication that impacted upon inpatient hospital care with a lack of liaison between wards and lack of communication between medical wards and the psychiatric wards at the point of discharge. Lack of communication between ward staff and family carers was also regarded as an important issue, as shown in the following quote:

> "It is information providing as well..., communication, and because of data-protection and confidentiality [ward staff] don't always..., they give the instructions to the patient, the person with dementia, but the relative could be saying, "you need to be telling me as well", and they say, – "oh no, no..." (Group A)

There were also comments from participants about a lack of transparency regarding the commissioning of care services whereby it was not always possible to identify the care provider supplying care to their clients. Nevertheless, some participants felt that good personal relationships with professional staff in other teams or agencies helped foster better information sharing and communication as detailed in the quotes below:

> "...they can commission that package of care from four or five different providers, so you are never quite sure who you liaising with..., often what you need is really clear communication..." (Group B)
> "...a lot of time is spent trying to negotiate care packages and where we do get things..., it's through personal influence..., we happen to know a social worker and it is like..., you scratch my back and I'll scratch yours..." (Group B)

Services working well

Focus group participants were asked to comment on aspects of dementia services that they felt were working well. Their comments are divided into two sub-themes, acute hospital care and community care provision.

Acute hospital care. Participants made positive comments regarding the involvement of hospital ward staff in the follow up of people with dementia after discharge. This process aided ward staff in their understanding of dementia and the process of care following discharge and consequently benefitted the person with dementia in modifying challenging behaviours. Participants also reported that good liaison between junior doctors, hospital discharge teams and the CMHTOP helped to improve patient outcomes and led to better inter-professional working, as illustrated in the quotes below:

> "...One of the things that... has worked well has been where we see people on the ward with dementia, we allow staff from the ward to follow them up into their care provision, so that has

made a big difference in people's behaviours . . . , most of them have found it has been a really useful experience to go out and see where people move onto . . . '' (Group B)
''They [junior doctors] could liaise with discharge liaison at the hospital . . . that would be the general stance because they actually work quite well with us sometimes. They are quite supportive of the situations that we find ourselves in. . . . .'' (Group A)

Participants also reported that the provision of training to ward staff to make wards more dementia friendly and improve the understanding of dementia had been well received. A number of participants commented that support by family carers was appreciated by staff on some wards although they noted that not all families could provide basic care due to other responsibilities:

''But it's welcomed on wards . . . it actually assists the nursing staff, they [family] go and feed and make sure they have sufficient to drink and help them to dress . . . , but a lot of families can't do that, either because of age . . . , or other employment responsibilities . . . '' (Group A)

Community care provision. Many community services were praised by participants and, as reported earlier, these included support provided by the HIT team, telecare, brokerage services, and a community dental service. The majority of participants also commented that many professional care staff demonstrated a wide knowledge about dementia, which helped with referrals and dementia specific treatments. They also reported improvements in primary care over a period of time with GPs being more responsive to the needs of people with dementia and having developed a greater awareness of dementia. The quotes below illustrate these:

''. . .community dentition were really good with somebody with very advanced dementia and we thought . . . , you know, would she even let anyone look in her mouth? . . . she has got a couple of fillings in . . . , I was quite surprised . . . '' (Group A)
''. . .the HIT team go in for emergency situations and they are very skilled and experienced people so they will be able to deliver a high standard of care'' (Group B)

The majority of participants in both groups felt that their service and role enabled positive results. They provided useful support and services to other trusts and health and social care professionals, and the dementia training provided by members of the CMHTOP greatly helped this. Participants also supported carers and people with dementia in a timely way with speedy follow-up services, personalised care plans and support groups, as illustrated in the quotes below:

''. . .support plans [are] more personalised in terms of one-to-one support, so more flexible, rather than just off the peg home care, daily routines. But we can actually specify on the care plan, what needs to be done and we specify what time that is required . . . '' (Group A)
'' . . . we run a group for the person and the carer together, and we have been using reminiscence life-story type work . . . and allowing people still to see the person rather than to see the disease, and . . . wherever we have done that with people, that has gone down really, really well . . . ''(Group B)

Services working less well

Participants were asked to describe what they regarded to be barriers to good service delivery for people with dementia. There were wide ranging responses to this question and comments

are reported in three sub-themes: acute hospital care; community care; and constraints to quality care.

Acute hospital care. The main areas of criticism were in relation to: information sharing; insufficient personal care; poor understanding of the nature of dementia and medication management; and pressure to discharge patients with dementia prematurely. A few participants commented on issues concerning medication management for the person with dementia, for example where the medication regime was stopped on admission and the person discharged without the correct dementia medication. Some identified a lack of information provided to the relatives of patients with dementia by acute hospital staff, and insufficient personal care mainly in respect of nutrition and fluids, with patients not receiving assistance with eating or drinking. Participants also raised contrasting issues of delays in referral to their team by ward staff, but also pressures to discharge from hospital prematurely as shown below:

> "We work with carers and relatives so we are often told the classic . . . , that 'we have been to visit the person in hospital and the meals are at the edge of the trolley', because nobody had the time to encourage that person to eat . . . , and things like taking fluids, . . . somebody who was diagnosed with being dehydrated, was alright when they went in hospital but . . . , at the end of the day, the carer is left to cope . . . " (Group A)
>
> ". . . what happens is that a referral to our liaison team is made very late on, so that the person's mental health has become a real issue and it is often getting in the way of them receiving physical health care, and a lot of the time . . . , the acute trust staff don't understand what is physical health and mental health." (Group B)
>
> "They are particularly keen on getting people out . . . , in fact . . . , probably quicker than they would with somebody who didn't have dementia. . ." (Group A)

Community care. The majority of comments from respondents in both focus groups were in relation to home care provision which was often judged to be neither sufficient in quantity nor adequately tailored for people with dementia and that better education and training were required for staff working with people with dementia. Many participants felt that home care staff did not have the appropriate skills to provide the correct quality of care to people with dementia, especially in relation to assisting with eating and drinking, and visits were deemed to be too short to deliver adequate care. This is illustrated in the quotes below:

> ". . . fifteen minutes might be OK if you are just going in and prompting somebody to take medication and they don't need anything else, but we have clients who require you to sit down and say, – 'you need to eat that, you need to drink that'. There's been one case quite recently where a lady, with our re-ablement team, who's been backward and forward in the acute side five times and each time it was for dehydration. . ." (Group B)
>
> "they do need someone to sit down and perhaps go through the paper with them so they have a clue what is going on in the world, or just to sit and talk about their family and help them make a phone call . . . you couldn't get that with the current home care service . . . "(Group A)
>
> ". . . the people actually delivering this care are paid the minimum wage and generally don't have the skills, knowledge or experience, and to me it is a very ageist way of approaching people with dementia . . . they may well have done some dementia training, but it is the quality of that training as well . . . " (Group B)

Participants reported difficulties in getting the correct care provision set up, care provision sufficient in quantity and appropriate to the idiosyncratic needs of a person with dementia as described below:

> "But it's a 'one size fits all' service . . . the 'normal' elderly person. . .their length of stay should be so long in hospital . . . , the 'normal' elderly person should be able to manage with one 15 minute visit a day, and a bath once a fortnight or something. . .our people don't fit into that. . ." (Group A)
> ". . . they are confronted with a patient that . . . , they have either had to clean or feed a patient . . . , 'choose one' – and frequently afterwards, we have to do the other and that is not sustainable . . . " (Group B)

Some participants thought the use of direct payments and personal budgets were problematic for some people with dementia due to the legalities and technicalities of employing a personal assistant or carer. Others reported problems encountered when accessing other services, such as physiotherapy, OT and podiatry. These services were not always responsive to the needs of dementia specific community care. These are illustrated in the quotes below:

> "One lady commissioned a package . . . through direct payment, so she is an employer. She hasn't got a clue about what employment rights are . . . , so ultimately it ends up that you end up doing it. . ." (Group B)
> "Most OT reports we get . . . would say this person's not safe at home . . . whereas we would recognise that it is an issue and we need to do what we can . . . , but an OT would say 'they are not safe . . . , they need 24 hour care' . . . " (Group A)

Constraints to quality care. Participants identified a number of constraints to quality care, in particular time pressures, financial restraints and the use of quality indicators and measures. Some participants encountered problems with hospital discharge which often provided insufficient time and opportunity to put in place a package of care once a person with dementia was deemed medically fit for discharge. A few respondents reported budgetary restraints, and monies not ring-fenced for dementia care causing delays in service provision to people with dementia, especially when newly diagnosed, as shown below:

> ". . . as soon as a patient on the ward is stated to be medically fit . . . , you would then [be] issued with a form to say this person needs to be off the ward . . . , if they've decided that person has got dementia and needs 24 hour care you don't have time without being penalised, to explore options of getting that person back home again and getting things in place . . . , getting the assessments etc that should take place, and that huge decision of somebody going in a [care] home . . . " (Group A)
> ". . . a lot of the budget that the PCTs [Primary Care Trusts] held for dementia has been handed over to the local authority . . . , and therein lies part of the problem, because it becomes a generic budget then and it is not ring-fenced . . . , the money came centrally from government for memory clinics, but we haven't seen any of that . . . " (Group B)

There were some respondents who felt that quality of dementia care had diminished due to implementation of measurement, counting, and quality indicators as part of management and performance. This had led to less time spent on hands-on care with the person with

dementia and more time given to providing data for quality measures. This was viewed negatively by respondents as shown below:

> "... the needs of the organisation have become so important, [compared to] the needs of the patient..., there's a dilution of quality care, and focus on the point of contact work has gone right down, whereas you could say that it has all become about how quality is measured..." (Group B)

Suggestions for service development and improvement

Focus group members were asked how current care services could be improved and further developed. There was felt to be inflexibility in services and a general lack of understanding about dementia specific care, evident on hospital wards and within other services, which some respondents felt could be addressed by the provision of education and training, as shown below:

> "... perhaps increased flexibility in visiting times, a lot of wards are very strict... and a lot of carers would be quite happy to go and help get the person they care for dressed in the mornings, to sit with them at mealtimes, carers often want go to the ward-round so they can get the information and they are not allowed to." (Group A)
> "I think sometimes very basic training, because sometimes on the ward... I don't think they're being awkward..., there is a lot of pressure on them to clear beds, I don't think [the ward staff] understand why somebody is wandering around..." (Group A)

Participants also reported that they would like a home care service that was tailored specifically for people with dementia. Indeed many participants wanted a specialist home care service specifically to cater for people with dementia. These are detailed in the quotes below:

> "... but like home care, at present you get four visits a day maximum, usually the service user has to fit in with the care agency and I would like it the other way round..." (Group A)
> "Sometimes I think a later service too, because we know that people with dementia, they can be quite disturbed in the evening, and the service has finished..." (Group A)
> "Specialist home care service..., people trained in dementia, – 'oh, I will have a drink later', [care staff] take that as written, or 'they just had one'..., to actually know that maybe, actually they haven't and to understand when to do things like that..." (Group B)

When asked about any service developments that would benefit care provided to people with dementia, participants gave a number of suggestions. Some were in relation to improving or adapting existing services, for example, an extended hours telephone helpline service to reassure people with dementia outside office hours; and a rapid response service, currently only for people with physical health problems made available to deal with crises tailored for people with dementia. A few participants commented that they would like to be able to undertake more regular and frequent follow up visits to their clients with dementia. Other comments related to services not currently available, for example group home living; and the creation of an approved list of formal carers

for those people with dementia using direct payments or personal budgets as illustrated below:

> "... have a group home type thing, like they have for learning disabilities, where about four or five people lived in that house, that is run by nurses and social services together, so like a big house with about four people..." (Group B)
> "I think it would be nice to have some sort of bank or list of approved, self employed people that perhaps were user-rated or something, it would make things much more simple, people could get more individualised support, because it's really difficult to get personal assistants..." (Group A)

Discussion

Focus group discussions, undertaken with members of two CMHTsOP, prompted wide-ranging views and comments in relation to health and social care for people with dementia and its service delivery. The most important aspects were in respect of: information sharing and communication; quality care in acute hospitals; flexibility and availability of community services; and specialist dementia home care provision. These are discussed below and considered in relation to national policies, recommendations and guidelines for the delivery of dementia care and suggestions for service development and improvement.

Information sharing and communication

A lack of effective information sharing was widely recounted in relation to electronic systems across a number of interfaces, in particular between CMHTsOP and social service departments. Incompatibility of IT systems has been identified as a problem nationally in older people's mental health services (Abendstern et al., 2010; Audit Commission, 2002; Healthcare Commission, 2009). Furthermore, recent research investigating joint working in CMHTsOP found only a third of teams could access social services client care records (Wilberforce et al., 2011). It has been suggested that greater integration between staff in health and social care services is a prerequisite to coordinated care and higher standards of dementia care (Healthcare Commission, 2009). Some participants identified problems with hospital wards not routinely sharing information with members of CMHTsOP or with relatives of the person with dementia. A recent audit found few acute hospitals had systems in place to share important patient information related to their dementia, and whilst taking account of patient confidentiality, recommended that family carers of people with dementia should be involved in care plans and decision making (Royal College of Psychiatrists, 2013). Focus group members reported that they provided dementia specific information, training and advice to other professionals and staff who were responsible for the care and treatment of people with dementia. This was carried out in various settings including care homes and in acute hospital wards. The provision of such training and advice by specialist mental health services was a key aim of the National Service Framework for Older People (Department of Health, 2001). However, provision of training by CMHTs has been reported mostly with family carers and care home staff and less frequently with acute hospital staff (Challis, von Abendorff, Brown, Chesterman, & Hughes, 2002; NAO, 2007; Tucker et al., 2007).

Quality care in acute hospitals

Quality of care for people with dementia in acute hospital settings provoked mixed views. Care in relation to patients' personal needs, ward visiting hours, awareness of the disease and hospital discharge prompted negative comments. Hospital discharge was problematic in the opinion of some participants when notice of discharge for patients with a diagnosis of dementia was insufficient for CMHTOP staff to ensure suitable arrangements were in place. A recent audit of dementia care in acute hospitals identified a need to give greater consideration to discharge planning (Royal College of Psychiatrists, 2013). In contrast, particular hospital services, specific wards and liaison teams were picked out for praise. Discharge liaison teams, designed to coordinate the transition of patients from hospital into an appropriate community setting, were reported to be working effectively with nursing staff and other professional teams. The value of liaison services has been widely acknowledged (Age Concern, 2007; Department of Health, 2008, 2009; Royal College of Psychiatrist, 2006). Specialist old age psychiatry liaison teams are based on the wards of an acute hospital to provide mental health assessment and input, clinical advice and training and refer patients to the CMHT if appropriate. Nevertheless, their availability has been found to be variable and service delivery inconsistent (Healthcare Commission, 2009; Tucker et al., 2007). Since this study was undertaken, the NHS Mental Health Trust in which the CMHTsOP were based began piloting an older people's liaison service to provide additional support to people with dementia in acute hospital settings. This initiative is based on the Birmingham rapid assessment interface and discharge (RAID) model (Birmingham RAID, 2013), and is designed to reduce inpatient stays and readmissions and assist with timely discharge. This model was found to be effective and compares favourably with traditional liaison psychiatry services (Singh, Ramakrishna, & Williamson, 2013).

Flexibility and availability of community services

Focus group members were generally critical of inflexibility in home care provision and in other professional services, for example physiotherapy and podiatry, which were perceived as less able to provide a service tailored for people with dementia. The availability of flexible, more creative and individualised services to fit the idiosyncratic nature of dementia were suggested by the groups, yet proposals for 'out of hours' home care, and one-to-one support by regular carers have been previously identified as priorities (Age Concern, 2007; Audit Commission, 2002). The importance of staff continuity has been further addressed by the national dementia strategy (Department of Health, 2009, 2012a) although comparatively high staff turnover in the care sector remains a problem (Centre for Workforce Intelligence, 2013; Eborall, Fenton & Woodrow, 2010). Interestingly, research has found that when specialist training in dementia care was made a contractual arrangement for the commissioning of home care services, there was lower staff turnover, suggesting fewer care staff leave the organisation when given training (Chester, Hughes, & Challis, 2013). There was overall agreement that the provision of dementia training for home care staff would help achieve better quality care for people with dementia. This concurs with guidance and recommendations over the last decade for the provision of dementia training for staff in all care settings (Age Concern, 2007; Audit Commission, 2002; NICE, 2010; Royal College of Psychiatrists, 2011, 2013). Some participants identified gaps in services, which meant that once diagnosed, there were few appropriate services for people with dementia and their

carers until the later stages of the illness. Implementation of peer support networks and an expansion of charitable and voluntary organisations providing support and information have been suggested as ways of supporting people with dementia following their diagnosis (Alzheimer's Society, 2012; Department of Health, 2009, 2012b).

Specialist dementia home care provision

There appeared to be general agreement that home care services were not always able to deliver appropriate care to support a person with dementia in the community. A number of participants felt that a specialist home care service, rather than a generic service, with appropriately trained staff could better cater for the more idiosyncratic nature of the disease, and meet the needs of people with both physical and mental health disabilities. Examples of existing specialist dementia home care services have suggested that these have advantages over generic services particularly in relation to: better continuity of care; staff retention; greater flexibility in responses to individual needs of the client; and reduced carer stress (Chilvers, 2003; Rothera et al., 2008; Snayde & Moriarty, 2009). However, a cross-sectional survey of home care services in the north west of England found few differences between the two types, whilst generic services appeared to offer more flexibility and intensive input, and specialist services provided more personalised care (Venables, Reilly, Challis, Hughes, & Abendstern, 2006). The authors acknowledged that specialist services, by their very nature, tended to be smaller and possibly provided other benefits not measured by the survey. A further survey using mixed methods of investigation found that both types delivered attributes of quality care. Whether services were deemed generic or specialist was less important to service users and carers than regular support at home from the same care worker, who is trained and knowledgeable about dementia care (Challis et al., 2011). The authors also concluded that both types of service could operate as complementary parts of a care plan designed for people with dementia.

Limitations

The focus groups were conducted with staff employed in a single Foundation NHS Mental Health Trust in north west England, an organisation which is part of the NHS in England. Therefore, the findings are limited to a geographical area of the country and may not be representative of all NHS Trusts in respect of national variability and service availability. Furthermore, staff in certain professions, for example psychology and OT, were unable to attend the groups and were thus not represented. Nevertheless, the participants were members of CMHTsOP of varying professional backgrounds, whose structure and composition were similar to other specialist mental health teams providing dementia care in England.

Conclusions and implications for practice

The views and comments expressed in the focus group discussions raised various issues in relation to the care of people with dementia in the twenty-first century. Many of these have become enduring themes in numerous policies and recommendations for older people or those with mental health problems. The findings highlight a number of areas of further enquiry for researchers and policymakers alike.

There is a need to bridge the health and social care divides more effectively, since problems associated with boundaries between acute and mental health care and primary and secondary care may have a detrimental effect upon the delivery of person-centred quality dementia care. Incompatible IT services, lack of information sharing and poor liaison between different care sectors appear to be impediments to effective interdisciplinary working, and consequently may impact upon the health and well-being of people with dementia. However, the introduction and implementation of specialist liaison teams within acute hospital settings may be beneficial in contributing to shorter stays and fewer hospital admissions. The integration of health and social care has been a long-held objective as one means of improving the delivery of care and providing co-ordinated care particularly for people with dementia (Audit Commission, 2011; Department of Health, 2001, 2012b). In Europe, health and social care co-ordination is a priority in long-term care policies for many member governments within the Organisation for Economic Cooperation and Development (OECD) (Prince, Prina, & Guerchet, 2013).

Programmes of dementia training for home care staff, and better staff retention to permit greater continuity of care, would appear to be prerequisites to improve the dementia care system. Further research into the provision of specialist dementia home care is needed to investigate whether specialist rather than generic services are advantageous to the delivery of home care for people with dementia (Challis et al., 2011). Of greater pertinence perhaps, would be a flexible and personalised service shaped around the needs of the individual (Challis et al., 2009). In England, the provision of appropriate training for staff caring for people with dementia has long been regarded as an important vehicle for the delivery of better quality care (Department of Health, 2001; Knapp et al., 2007; NICE, 2010; Skills for Care & Skills for Health, 2011). This is also the case in many developed countries and whilst it is suggested that training may reduce staff turnover, nevertheless, evidence for such a link has yet to be established (Fujisawa & Colombo, 2009).

The pursuit of quality measures, tightly defined targets and monies not ring-fenced for dementia care also appear to act as constraints to care. Cost containment is a major priority in long-term care for many European governments (Prince et al., 2013). Since demand and costs for formal community care services is set to increase in the UK (Comas-Herra, Wittenberg, Pickard, & Knapp, 2007), economic evaluations are required and a system of adequate funding for dementia care based on evidence is warranted.

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References

Abendstern, M., Hughes, J., Clarkson, P., Sutcliffe, C., Wilson, K., & Challis, D. (2010). 'We need to talk': Communication between primary care trusts and other health and social care agencies following the introduction of the single assessment process for older people in England. *Primary Health Care Research and Development*, *11*, 61–71.

Age Concern. (2007). *Improving services and support for older people with mental health problems: The second report from the UK Inquiry into mental health and well-being in later life*. London: Age Concern.

Alzheimer's Society. (2009). *Counting the cost*. London: Alzheimer's Society.

Alzheimer's Society. (2012). *Dementia 2012: A national challenge*. London: Alzheimer's Society.

Audit Commission. (2002). *Forget me not 2002: Developing mental health services for older people in England*. London: Audit Commission.

Audit Commission. (2011). *Joining up health and social care*. London: Audit Commission.

Australian Health Ministers' Conference. (2006). *National framework for action on dementia 2006-2010*. Retrieved from www.health.gov.au/internet/main/publishing.nsf/content/BB7EC10AAE500E00CA257BF0001A8D22/$File/NFAD%20low%20res%20Web%20Version%20Oct%2006.pdf

Birmingham RAID. (2013). Retrieved from http://www.bsmhft.nhs.uk/our-services/rapid-assessment-interface-and-discharge-raid/

Callaly, T., & Fletcher, A. (2005). Providing integrated mental health services: A policy and management perspective. *Australasian Psychiatry*, *13*(4), 351–356.

Centre for Workforce Intelligence. (2013). *Planning and developing the adult social care workforce: Risks and opportunities for employers*. Retrieved from http://www.cfwi.org.uk/workforce-planning-news-andreview/publications/planning-and-developing-the-adult-social-care-workforce-risks-and-opportunities-for-employers

Challis, D. J., von Abendorff, R., Brown, P., Chesterman, J., & Hughes, J. (2002). Care management, dementia care and specialist mental health services: An evaluation. *International Journal of Geriatric Psychiatry*, *17*, 315–325.

Challis, D., Sutcliffe, C., Hughes, J., von Abendorff, R., Brown, P., & Chesterman, J. (2009). *Supporting people with dementia at home: Challenges and opportunities for the 21st Century*. Surrey: Ashgate.

Challis, D., Clarkson, P., Hughes, J., Chester, H., Davies, S., Sutcliffe, C., . . . Wilberforce, M. (2011). *Community support services for people with dementia: The relative costs and benefits of specialist and generic domiciliary care services – Expert briefing paper 2*. Manchester: Personal Social Services Research Unit on behalf of the Department of Health Policy Unit, University of Manchester.

Chester, H., Hughes, J., & Challis, D. (2014). Commissioning social care for older people: Influencing the quality of direct care. *Ageing and Society*, *34*, 930–950.

Chilvers, D. (2003). The case for specialist home care for people with dementia. *Journal of Dementia Care, Jan/Feb*, 20–21.

Comas-Herra, A., Wittenberg, R., Pickard, L., & Knapp, M. (2007). Cognitive impairment in older people: Future demand for long-term care services and the associated costs. *International Journal of Geriatric Psychiatry*, *22*, 1037–1045.

Department of Health. (2000). *The NHS Plan: A plan for investment, a plan for reform. Cm 4818-1*. London: The Stationery Office.

Department of Health. (2001). *The national service framework for older people*. London: Department of Health.

Department of Health. (2008). *Transforming the quality of dementia care*. London: Department of Health.

Department of Health. (2009). *Living well with dementia. A national dementia strategy*. London: Department of Health.

Department of Health. (2012a). *Prime Minister's challenge on dementia – Delivering major improvements in dementia care and research by 2015*. London: Department of Health.

Department of Health. (2012b). *Caring for our future: Reforming care and support. Cm 8378*. London: The Stationery Office.

Department of Health & CSIP. (2005). *Everybody's business. Integrated mental health services for older adults: A service development guide*. London: Department of Health.

Eborall, C., Fenton, W., & Woodrow, S. (2010). *The state of the adult social care workforce in England, 2010: The fourth report of Skills for Care's research and analysis units*. Leeds: Skills for Care.

Ferri, C. P., Prince, M., Brayne, C., Brodaty, H., Fratiglioni, L., Ganguli, M., ... Scazufca, M.; for Alzheimer's Disease International. (2005). Global prevalence of dementia: A delphi consensus study. *Lancet*, *366*, 2112–2117.

Fujisawa, R., & Colombo, F. (2009). *The long-term workforce: Overview and strategies to adapt supply to a growing demand, OECD Health Working Papers No. 44*. Paris: Directorate for Employment, Labour and Social Affairs, OECD.

Guisset-Martinez, M. (2012). Three alzheimer plans in France (2008-2012). In A. Innes, F. Kelly, & L. McCabe (Eds.), *Key issues in evolving dementia care – International theory-based policy and practice* (pp. 122–136). London: Jessica Kingsley.

Healthcare Commission. (2009). *Equality in later life: A national study of older people's mental health services*. London: Health Care Commission.

Huxley, P. J., Evans, S., Baker, C. M., White, J., Philpin, S. A., Onyett, S., ... Gould, N. (2011). *Integration of social care staff within community mental health teams*. Final report. National Institute of Health Research Service Delivery and Organisation programme. London: HMSO.

Knapp, M., Prince, M., Albanese, E., Banerjee, S., Dhanasiri, S., Fernandez, J. L., ... Stewart, R. (2007). *Dementia UK: The full report*. London: Alzheimer's Society.

Kodner, D. L. (2006). Whole-system approaches to health and social care partnerships for the frail elderly: An exploration of North American models and lessons. *Health and Social Care in the Community*, *14*(5), 384–390.

Mental Health Commission of Canada. (2011). *Guidelines for comprehensive mental health services for older adults in Canada*. Alberta: Mental Health Commission of Canada.

National Audit Office. (2007). *Improving services and support for people with dementia*. London: The Stationary Office.

National Institute for Health and Clinical Excellence (NICE) – Social Care Institute for Excellence (SCIE). (2006). *NICE SCIE guideline to improve care of people with dementia*. Retrieved from www.nice.org.uk/nicemedia/live/10998/30323/30323.pdf

National Institute for Health and Clinical Excellence (NICE). (2010). *Dementia quality standard*. Retrieved from http://pathways.nice.org.uk/pathways/dementia/dementia-overview#content=view-node%3Anodes-staff-training

National Statistics. (2009). *Community care statistics 2008. Home care services for adults, England*. Leeds, United Kingdom: The Health and Social Care information Centre.

National Statistics. (2013). *Community care statistics, Social services activity – England, 2011-2012, Final release*. Leeds: The Health and Social Care information Centre.

Norwegian Ministry of Health and Care Services. (2007). *Dementia plan 2015*. Oslo: Norwegian Ministry of Health and Care Services.

Prince, M., & 10/66 Dementia Research Group. (2004). Care arrangements for people with dementia in developing countries. *International Journal of Geriatric Psychiatry*, *19*, 170–177.

Prince, M., Livingston, G., & Katona. (2007). Mental health care for the elderly in low income countries: A health system approach. *World Psychiatry*, *6*, 5–13.

Prince, M., Prina, M., & Guerchet, M. (2013). *World Alzheimer report 2013. Journey of caring: An analysis of long-term care for dementia*. London: Alzheimer's Disease International.

Rothera, I., Jones, R., Harwood, R., Avery, A. J., Fishe, K., James, V., . . . Waite, J. (2008). An evaluation of a specialist multiagency home support service for older people with dementia using qualitative methods. *International Journal of Geriatric Psychiatry*, *23*, 65–72.

Royal College of Psychiatrists. (2006). *Raising the standard: Specialist services for older people with mental illness. Report of the faculty of old age psychiatry*. London: Royal College of Psychiatrists.

Royal College of Psychiatrists. (2011). *Report of the national audit of dementia care in general hospitals 2011*. London: Royal College of Psychiatrists.

Royal College of Psychiatrists. (2013). *Report of the national audit of dementia care in general hospitals 2012-13. Second round audit report and update*. London: Royal College of Psychiatrists.

Singh, I., Ramakrishna, S., & Williamson, K. (2013). The rapid assessment and interface and discharge service and its implications for patients with dementia. *Clinical Interventions in Aging*, *8*, 1101–1108. doi: 10.2147/CIA.S36398.

Skills for Care & Skills for Health. (2011). *Common core principles for supporting people with dementia: A guide to training the social care and health workforce*. Leeds: Skills for Care and Skills for Health.

Snayde, F., & Moriarty, J. (2009). Person-centred home care for people with dementia: Developing a specialist service in an ethnically diverse community. *Dementia*, *8*, 148–151.

Stevens, P. E. (1996). Focus groups: Collecting aggregate-level data to understand community health phenomena. *Public Health Nursing*, *13*(3), 170–176.

Sutcliffe, C., Roe, B., Jasper, R., Jolley, D., & Challis, D. J. (2013). People with dementia and carers' experiences of dementia care and services: Outcomes of a focus group study. *Dementia,* doi: 10.1177/1471301213511957.

Toot, S., Devine, M., Akporobaro, A., & Orrell, M. (2013). Causes of hospital admission for people with dementia: A systematic review and meta-analysis. *Journal of the American Medical Directors Association*, *14*(7), 463–470.

Tucker, S., Baldwin, R., Hughes, J., Benbow, S., Barker, A., Burns, A., . . . Challis, D. (2007). Old age mental health services in England: Implementing the national service framework for older people. *International Journal of Geriatric Psychiatry*, *22*, 211–217.

Tucker, S., Baldwin, R., Hughes, J., Benbow, S., Barker, A., Burns, A., . . . Challis, D. (2009). Integrating mental health services for older people in England – From rhetoric to reality. *Journal of Interprofessional Care*, *23*(4), 341–354.

Venables, D., Reilly, S., Challis, D., Hughes, J., & Abendstern, M. (2006). Standards of care in home care services: A comparison of generic and specialist services for older people with dementia. *Aging and Mental Health*, *10*(2), 187–194.

Verbeek, H., Meyer, G., Leino-Kilpi, H., Zabalegui, A., Hallberg, I. R., Saks, K., . . . Hamers, J. P. H., & the *RightTimePlaceCare* Consortium. (2012). A European study investigating patterns of transition from home care towards institutional dementia care: The protocol of a RightTimePlaceCare study. *BMC Public Health*, *12,* 68.

Wilberforce, M., Harrington, V., Brand, C., Tucker, S., Abendstern, M., & Challis, D. (2011). Towards integrated community mental health teams for older people in England: Progress and new insights. *International Journal of Geriatric Psychiatry*, *26*, 221–228.

Wimo, A., Jönsson, L., Bond, J., Prince, M., Winblad, B., on behalf of Alzheimer Disease International. (2013). The worldwide economic impact of dementia 2010. *Alzheimer's and Dementia*, *9*, 1–11.

World Health Organisation Europe. (2008). *Policies and practices for mental health in Europe – Meeting the challenges*. Copenhagen: WHO Regional Office for Europe.

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